

Screening, Brief Intervention and Referral to Treatment (SBIRT) Program

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Screening, Brief Intervention and Referral to Treatment (SBIRT) Services

Program Overview

The Colorado Medical Assistance Program reimburses providers for medically necessary medical and surgical services furnished to eligible members.

The purpose of this document is to provide Colorado clinic and administrative staff with guidance on obtaining Medicaid reimbursement for SBIRT services. Please note: this document is updated periodically to reflect future changes in policy and regulation.

The Screening, Brief Intervention and Referral to Treatment (SBIRT) benefit under the authority of [Program Rule 10 CCR 2505-10 8.747](#) authorizes coverage of SBIRT as a benefit of the Colorado Medical Assistance Program. Reimbursement for this benefit is available for eligible providers in order to assess and intervene in potentially risky substance use behaviors for members aged 12 and up.

Providers should refer to the Code of Colorado Regulations, [Program Rule 10 CCR 2505-10 8.747](#), for specific information when providing SBIRT services.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests for paper claim submission may be sent to the Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:



- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message “Electronic Filing Required.”

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department's website.
- Web Portal User Guide (via within the portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal ([Web Portal](#)) or via batch submission through a host system.

For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department's website (Colorado.gov/hcpf) → For Our Providers → Provider Services → [Billing Manuals](#).

Background Information

Most of the clinical sites that have been working with [SBIRT Colorado](#) to implement alcohol and drug screening, brief intervention, and referral-to-treatment (SBIRT) services are supported through grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Overview on the Status of Billing Recognition

There are designated procedure codes that must be used for purposes of reimbursement for SBIRT services. However, great care must be taken to ensure compliance in service delivery and claim submission.

Key Clinical Definitions

This section provides an overview of the key clinical definitions integral to the provision of SBIRT services and the related billing definitions of such services.

Note: Tobacco alone is not a SBIRT benefit. If billing SBIRT, tobacco MUST be co-occurring with another substance such as alcohol or drugs.

Pre-Screen (aka Brief Screen)

A pre-screen is defined by the SAMHSA as "a rapid, proactive procedure to identify individuals who may have a condition or be at risk for a condition before obvious manifestations occur." A pre-screen may involve one to several short questions relating to drinking and drug use. A brief alcohol and/or drug screen is considered an integral part of routine preventive care and is therefore not separately reimbursable by the Colorado Medical Assistance Program.



Full Screen

Full screen entails asking members a validated series of questions in order to assess the level of a member's substance use. Full screens are indicated for members with positive brief screens and for

members with signs, symptoms, and medical conditions that suggest risky or problem drinking or drug use.

The Colorado Medical Assistance Program policy indicates screening should be used as a primary method for educating members about the health effects of using alcohol and other drugs. The Colorado Medical Assistance Program intends to cover screening services in a wide variety of settings to increase the chance of identifying individuals at risk for future substance abuse.

A few brief questions may be asked to identify those member's who would benefit from a more in-depth screening. Asking a few questions is a pre-screen and is not a reimbursable service.

Providers are required to use an evidence-based screening tool to identify members at risk for substance abuse problems. The screening tool should be simple enough to be administered by a wide range of health care professionals. The tool must demonstrate sufficient evidence of validity and reliability to accurately identify members at potential risk for substance abuse disorder. Enough information must be generated from utilizing the tool to customize an appropriate intervention based on the identified level of substance use. Providers may use more than one screening tool during the screening process if appropriate; however, no additional reimbursement will be made.



The Colorado Medical Assistance Program has approved several evidence-based screening tools and will update the list as new methods become available. Providers may choose a tool that is not on the approved list; however, providers who wish to use a screening tool that is not on the list will be required to submit the screening tool to the Department's SBIRT benefit manager to review for best practices.

Areas of focus for any evidence-based screening tool must include:

- The quantity and frequency of substance use over a particular period of time (generally 1 to 12 months).
- Problems related to substance use.
- Dependence symptoms.
- Injection drug use.

The current approved evidence-based screening tools are:

- The Alcohol Use Disorders Inventory Test (AUDIT)
- The Drug Abuse Screening Test (DAST)
- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- The CRAFFT, which has been validated for adolescents
- The Problem Oriented Screening Instrument for Teenagers (POSIT)

Brief Intervention

Brief interventions are interactions with members which are intended to induce a change in a health-related behavior. Often one to three follow-up contacts are provided to assess and promote progress and to evaluate the need for additional services. Brief interventions are typically used as a management strategy for members with risky or problem drinking or drug use who are not dependent. This includes members who may or may not qualify for a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnosis of alcohol or drug abuse.

Brief substance abuse intervention services are covered for members who through the use of an evidence-based screening tool, are identified as at-risk for a substance abuse disorder(s). Brief intervention may be single or multiple sessions focused on motivational discussion that increases insight and awareness regarding substance use and motivation toward changes in behavior. Alternatively, brief intervention may also be used as a method of increasing motivation and acceptance of a referral for substance abuse treatment. Intervention services may occur on the same date of service as the screening or on a later date. Brief intervention is not covered prior to screening.



Although the Colorado Medical Assistance Program is not endorsing a specific approach for intervention, providers are required to use effective strategies for counseling and intervention.

Examples of demonstrated effective strategies include the following:

- The SBIRT protocols available at <http://www.samhsa.gov/prevention/sbirt/>
- “Helping Patients Who Drink Too Much,” A Clinician’s Guide, Updated 2005 Edition available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm.

Follow-up

Follow-up services include interactions which occur after initial intervention, treatment, or referral services, and which are intended to reassess a patient's status, assess a patient's progress, promote or sustain a reduction in alcohol or drug use, and/or assess a patient's need for additional services.

Referral

Members who are likely alcohol or drug dependent are typically referred to alcohol and drug treatment experts for more definitive, in-depth screening, intervention and, if warranted, treatment.

Clinical Service Definitions for Billing

Billable services are referred to as either full screening or brief intervention services.

Screening

For billing purposes, screening is defined as administration by a SBIRT qualified provider of a Colorado Medical Assistance Program approved full screening tool as noted in Key Clinical Definitions above. Administration of a pre-screen is not a Colorado Medical Assistance Program billable service.

Intervention

For billing purposes, a brief intervention is defined as a period of time of at least 15 minutes of intervention *after* a positive full screen has been obtained.

A billable intervention service could be any of the following:

- Brief Intervention
- Follow-up
- Referral is made or attempted

Eligible Providers

SBIRT Service Eligible Providers

SBIRT providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program member; and
- Submit claims for payment to the Colorado Medical Assistance Program.

Ancillary providers, such as health educators, are non-credentialed providers and must perform services under the direct supervision of a credentialed provider. The definition of direct supervision varies based on payer. For services performed by ancillary staff, best practices would suggest the credentialed provider be on the premises and directly available to intervene if necessary. Additionally, the credentialed provider should co-sign the documentation prior to submitting the claim for payment. Any ancillary services should adhere to an established plan of care.



Training and Requirements for Eligible Providers

In an effort to maximize early detection and treatment of substance abuse problems, the Colorado Medical Assistance Program is allowing a wide scope of eligible providers to administer these services. Therefore, the Department has outlined training requirements for both licensed and unlicensed individuals. Providers are required to retain documentation confirming that staff providing screening and intervention services meet the training, education, and supervision requirements.

Training for Licensed and Unlicensed Health Care Professionals

In order to directly deliver screening and intervention services, it is recommended that health care professionals participate in a training that provides information about the implementation of evidence-based protocols for screening, brief interventions, and referrals to treatment. Trainings are available through various entities such as [SBIRT Colorado](#), [Health TeamWorks](#), [Colorado Community Managed Care Network](#), and the [Emergency Nurses Association](#). Online SBIRT Training: The *Substance Use SBIRTmentor* is an interactive, online training opportunity. The training offers three (3) continuing education credits and can be accessed at www.CMEcorner.com/SBIRT. This skills-based training was developed in collaboration with the SBIRT Colorado initiative, Peer Assistance Services, Inc., MedRespond, and NORC at the University of Chicago. Other online training modules can be found at www.sbirtraining.com/SBIRT-Core.

Unlicensed health care professionals, that have completed a minimum of 60 hours professional training (e.g. education) which includes a minimum of four (4) hours of training directly related to SBIRT **and** 30 hours of face-to-face member contact (e.g. practicum or internship) **within their respective fields**, may provide SBIRT services under the supervision of a licensed health care professional.

Procedure/HCPCS Codes Overview

The codes used to report Colorado SBIRT services for reimbursement are consistent among all provider types. This section will provide a comprehensive overview of the fundamental elements necessary to determine how to report SBIRT services in various billing scenarios. It is important to note that a provider may not submit for reimbursement with both the Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) codes. The provider must use **either** the CPT **or** the HCPCS codes designated for SBIRT services.

SBIRT Coding

The Department accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program members and represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two (2) principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT, a numeric coding system maintained by the American Medical Association (AMA).

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits, while CPT codes are identified using five numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services [Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by completing and submitting a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

CPT Codes (Federally Qualified Health Centers [FQHC] only)

Guidance for procedure code 99408 and 99409: “A screening & brief intervention (SBI) describes a different type of patient-physician interaction. It requires a significant amount of time and additional acquired skills to deliver beyond that required for provision of general advice. Screening & brief intervention techniques are discrete, clearly distinguishable clinical procedures that are effective in identifying problematic alcohol or substance use.” The importance of screening and intervening for those members who aren’t necessarily identified as abusers and a comprehensive list of components that should be included in provision of the codes was also outlined.

The components include, but are not limited to:

- The use of a standardized screening tool;
- The patient receives feedback concerning the screening results;
- Discussion of negative consequences that have occurred; and the overall severity of the problem;
- Motivating the patient toward behavioral change;
- A joint decision-making process regarding alcohol and/or drug use; and
- Plans for follow up are discussed with member and agreed to.

Ancillary staff, including health educators, may perform SBIRT services under the supervision of a credentialed provider. The services should relate to a plan of care and will require billing under the supervising physician. SBIRT services that do not meet the minimum fifteen (15) minute threshold are not separately reimbursable. The CPT codes below were created to be reported when SBIRT services are performed by physicians:

- **99408** - Alcohol and/or substance use structured screening (e.g., AUDIT, DAST, CRAAFT), and brief intervention services; 15-30 minutes.
- **99409** - Alcohol and/or substance use structured screening (e.g., AUDIT, DAST, CRAAFT), and brief intervention services; greater than 30 minutes.

It is important to note that these are time-based codes; therefore, documentation must denote start/stop time or total face-to-face time with the member. Due to procedure code 99409 being inclusive of the time spent before 30 minutes was accumulated, the two codes may not be billed together on the same date of service. Both codes account for screening *and* brief intervention, therefore state fiscal yearly limits for *screening* and *brief intervention* apply to each.

*Note: The state fiscal year is July 1st through June 30th.

HCPCS Codes (Non-FQHC Providers)

The Colorado Medical Assistance Program recognizes HCPCS codes for reporting the provision of SBIRT services. Typically, this decision is made because the language of the CPT codes is either too broad or does not accurately capture the reason(s) the Colorado Medical Assistance Program will make payment.

As a direct result of Program Rule 8.747, the Colorado Medical Assistance Program has implemented the SBIRT benefit resulting in the acknowledgement and acceptance of two (2) additional HCPCS codes.

These codes are used for reporting SBIRT services when provided by both credentialed providers and when ancillary staff performs SBIRT services under the supervision of credentialed providers.

- **H0049** - Alcohol and/or drug screening.
- **H0050** - Alcohol and/or drug service, brief intervention, per 15 minutes.

It is important to note that a provider may not submit for reimbursement using both the CPT and HCPCS codes. If the provider is requesting reimbursement for SBIRT services using HCPCS codes, they may not use CPT codes for the same service and vice versa.

Colorado Medical Assistance Program members who are pregnant may be eligible for additional substance abuse screening and intervention services through [Special Connections](#), Outpatient Substance Abuse treatment, and the [Prenatal Plus program](#).

Evaluation and Management Coding (E&M)

There may be instances when ancillary providers, including health educators, are providing SBIRT services and based on payer requirements, the SBIRT services are not reportable using one of the CPT or HCPCS codes defined above. For example, when billing the Colorado Medical Assistance Program, SBIRT services will need to be submitted under the supervising provider's Colorado Medical Assistance Program provider number.

There are seven (7) key components to an E&M code which are used to define a level of service (LOS) and they are:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three (3) of these components (history, examination, and medical decision making) are the key components used in selecting a level of E&M service. An exception to this rule is the case when visits consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E&M service. The most applicable E&M code that might be reported by ancillary staff, including health educators, when providing SBIRT services is representative of established members, whether using components of counseling or coordination of care to determine LOS.

- **99212** – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two (3) of three (3) key components

It is expected the documentation contain elements of both evaluation and decision making. When billing 99212, which would be allowed as an ancillary service billed to the Colorado Medical Assistance Program, documentation of at least two (2) of the three (3) (history, exam and medical decision making) elements is required.

In the case where counseling and/or coordination of care dominates more than fifty percent (50%) of the face-to-face time, it is considered the key or controlling factor in determining the LOS. The start and stop time or total length of the E&M must be documented in the medical record. Additionally, the face-to-face counseling and/or activities involved in coordinating care must be described and documented the medical record.

Diagnosis Codes

The International Classification of Diseases, Clinical Modification, Ninth Revision (ICD-9-CM), is currently used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization. Diagnosis codes play a critical role in supporting the medical necessity of the CPT or HCPCS codes that are performed. Below is a table of common diagnosis codes for reporting SBIRT services.

Common ICD-9 Codes Used for SBIRT	
V82.9	Screening for Unspecified Condition
V28.9	Unspecified Antenatal Screening
V65.40	Other Counseling, Not Otherwise Specified (NOS)
V65.42	Other Counseling, Substance Use and Abuse
V65.49	Other Specified Counseling

Site of Service

Another component that must be considered when billing SBIRT services for Colorado Medical Assistance Program members is the site of service. Reimbursement methodologies will vary based on the location where the service is provided. An example of this is in the medical office setting or Community Health Center.

Reimbursement Fundamentals

It is important to understand the basic fundamentals of how services are reimbursed. The Colorado Medical Assistance Program reimburses for SBIRT using a “fee schedule” methodology. Reimbursement is based on what is considered to be “usual and customary” in a specific geographic area.

Understanding fee schedules will help with understanding reimbursement.

Billing and Reimbursement

The following section will provide guidance on eligibility, coverage, billing & coding, reimbursement, and documentation requirements when SBIRT services are provided and then billed by physicians and ancillary staff, including health educators, to the Colorado Medical Assistance Program.

Note: The Colorado Medical Assistance Program covers SBIRT services for all members age 12 and older.

Member Eligibility

The SBIRT benefit is available to members enrolled in Colorado medical assistance programs. Members enrolled in a Medicaid HMO or managed care organization (MCO) must receive SBIRT services through the HMO. The SBIRT benefit is available to HMO and MCO members that are 12 years of age or older on the date of service.

Screening & Intervention Services

The substance abuse screening and intervention services are designed to prevent members from developing a substance abuse disorder or for early detection. These services are not intended to treat members already diagnosed with a substance abuse disorder or those members already receiving substance abuse treatment services.

SBIRT services are not designed to address smoking and tobacco cessation services unless it is a co-occurring diagnosis with another substance such as drugs or alcohol. Tobacco **only** services are not a SBIRT billable benefit.

SBIRT services must be provided face-to-face, in-person or via simultaneous audio and video transmission (telemedicine) with the member. A physician prescription is not required for screening or intervention. Below is a table of allowable places of service, which would be reported on a CMS 1500 paper claim form or on an 837P transaction:

Allowable Place of Service Codes	
03	School
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
99	Other Place of Service

Emergency Department

When providing SBIRT services in the hospital emergency department, there is commonly both a facility and professional fee. Services performed in the emergency department are provided by physicians and Colorado Medical Assistance Program enrolled non-physician practitioners that are not employed by the facility.

For purposes of SBIRT, physicians and other Colorado Medical Assistance Program enrolled non-physician practitioners may bill SBIRT codes H0049 and H0050 for direct payment when performed in the emergency department. The diagnosis reported on the claim always requires a sign, symptom, illness or injury.

If ancillary staff, such as health educators, employed by the facility provides SBIRT services to Medicare beneficiaries in the emergency department setting, the charges will be rolled into the facility payment. Since incident-to will not apply in the hospital setting, including emergency departments, ancillary staff is unable to provide SBIRT services as incident-to a physician or non-physician practitioner in the emergency department setting.



Federally Qualified Health Centers (FQHCs) / Rural Health Clinics (RHC)

Payment to independent provider-based FQHCs and RHCs for covered RHC/FQHC services furnished to Medicaid beneficiaries is made through an all-inclusive rate for each visit. The encounter rate includes covered services provided by an FQHC/RHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse; and related services and supplies.

The term “visit” is defined as a face-to-face encounter between the Medicaid beneficiary and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC/RHC service is rendered.

Encounters with more than one health professional and multiple encounters with the same health professionals which take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or
The patient has a medical visit and a clinical psychologist or clinical social worker visit.

When SBIRT services are provided to Medicaid beneficiaries in a FQHC/RHC, they are included in the encounter rate and no separate payment is made, regardless of who is providing the service. For additional information on FQHC/RHC billing and reimbursement, see the Medicare Claims Processing Manual, Chapter 9, located at [Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers \[PDF, 215KB\]](#).

Resident Billing

The Centers for Medicare and Medicaid Services (CMS) defines "residents" as:

Physicians participating in approved postgraduate training programs, and

Physicians who are not in approved programs but who are authorized to practice only in a hospital setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

Where a senior resident has a staff or faculty appointment or is designated as a "fellow," it does not change the resident's status for the purposes of Medicaid coverage and payment. As a general rule, Medicaid fiscal intermediaries make payment directly to the hospital for services of residents.

For additional information on residency billing as part of Graduate Medical Education (GME) or for SBIRT services provided under the supervision of the teaching physician see Chapter 12, section 100 of the CMS Manual System located at [Chapter 12 - Physicians/Nonphysician Practitioners \[PDF, 1MB\]](#).

Moonlighting Services Provided Outside the Scope of Approved Training Programs

Medical and surgical services furnished by residents that are not related to their training program, and are performed *outside the facility* where they receive their training, i.e.; in an urgent care clinic, are covered by the Colorado Medical Assistance Program as physician services only when both of the following requirements are met:



The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient's condition; and,

The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed.

When both of the above requirements are met, the services are considered to have been performed by residents in their capacity as physicians. When resident physicians meet these requirements, they may bill the Colorado Medical Assistance Program directly for reimbursement. This would include reimbursement for the provision of SBIRT services when provided.

Medical and surgical services furnished by residents that are not related to their training program, and are performed *in an outpatient department or emergency room of the facility* where they receive their training, are covered as physicians' services only when all three (3) of the following are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient's condition;

- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed; and
- The services performed can be separately identified from those services that are required as part of the training program.

When these three (3) criteria are met, the residents' hospital outpatient department and emergency room services are considered to have been furnished by the residents in their capacity as physicians. When resident physicians meet these requirements, they may bill the Colorado Medical Assistance Program directly for reimbursement. This would include reimbursement for the provision of SBIRT services when provided.

When residents are performing services in their capacity as physicians, they must be covered under medical malpractice insurance and no payment will be made to a teaching physician. When residents are functioning in the physician capacity, they may also supervise ancillary staff and bill such services to the Colorado Medical Assistance Program.

For additional information on resident billing or teaching physician guidelines, see the Guidelines for Teaching Physicians, Interns, and Residents publication located at <http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf>.

Benefit Requirements

The SBIRT benefit will correspond with two (2) HCPCS procedure codes, as noted previously in this manual. Both screening and brief intervention will require specific diagnosis codes on the claim. The SBIRT benefit does not require a prior authorization request (PAR). Providers are required to retain documentation concerning the health care professional's education, training, and supervision for provision of SBIRT services.

Screening Requirements

For any Colorado Medical Assistance Program member, SBIRT screening is limited to two (2) units of service per state fiscal year. When using procedure code H0049, a unit of service is equivalent to the total amount of time required to administer the screening. Therefore, when billing the screening a unit of service should always equal one (1) regardless of time spent completing the screening.

In addition to documenting the service, providers using an electronic health record (EHR) should document in the EHR what screening tool was used and the member's responses to the screening questions. In order to meet this requirement, it is permissible to document the overall results of the screening in the EHR. The completed screening tool should be available for review in the event of an audit.

To report screening under the SBIRT benefit, use procedure code H0049. An appropriate diagnosis may be V82.9, "Screening for Unspecified Condition."

Substance Abuse Screening Coding & Billing Requirements				
Procedure Code	Description	Modifier	Potential Diagnosis	Units of Service
H0049 SBIRT Benefit	Alcohol and/or drug screening (e.g. AUDIT, DAST, CRAFFT, etc.)	<i>No modifiers may be applied.</i>	V82.9	One (1) per day, limited to two (2) per state fiscal year.

Intervention Requirements

For any Colorado Medical Assistance Program member, SBIRT brief intervention services are limited to two (2) sessions per state fiscal year. Sessions are composed of up to two (2) units of service each, meaning there is a four (4) unit limit per state fiscal year. A unit of brief intervention service is 15 minutes in length. Intervention services may be provided on the same or later date of the screening.

To report SBIRT intervention services use procedure code H0050. An appropriate diagnosis may be V65.42, "Other Counseling, Substance Use and Abuse."

Intervention Coding & Billing Requirements				
Procedure Code	Description	Modifier	Potential Diagnosis	Unit of Service
H0050 SBIRT Benefit	Alcohol and/or drug service, brief intervention, per 15 minutes	<i>No modifiers may be applied.</i>	V65.42	Up to two (2) per day, limited to four (4) per state fiscal year.

Reimbursement

Reimbursement for SBIRT services will be made at the lesser of the provider's usual and customary charge or the Colorado Medical Assistance Program maximum allowable fee for the service. The Colorado Medical Assistance Program will pay for separate and additional services on the same day as



SBIRT, including medically necessary E&M services. The SBIRT codes will not be separately reimbursed when billing under the Mental Health and Substance Abuse Screening benefit using codes H0002 and H0004, or with any other HCPCS or CPT code that represents the same or similar services. Claims cannot be submitted using both CPT and HCPCS codes designated for SBIRT services (e.g. 99408 and H0049 or 99409 and H0050.)

CMS 1500 Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 paper claim form.

CMS Field #	Field Label	Field is?	Instructions
1	Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a	Insured's ID Number	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	Patient's Name	Required	Enter the member's last name, first name, and middle initial.
3	Patient's Date of Birth / Sex	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two

CMS Field #	Field Label	Field is?	Instructions
			<p>digits for the year. Example: 070114 for July 1, 2014.</p> <p>Place an "X" in the appropriate box to indicate the sex of the member.</p>
4	Insured's Name	Conditional	<p>Complete if the member is covered by a Medicare health insurance policy.</p> <p>Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.</p>
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Conditional	<p>Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.</p>
7	Insured's Address	Not Required	
8	Reserved for NUCC Use		
9	Other Insured's Name	Conditional	<p>If field 11d is marked "YES", enter the insured's last name, first name and middle initial.</p>
9a	Other Insured's Policy or Group Number	Conditional	<p>If field 11d is marked "YES", enter the policy or group number.</p>
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Conditional	<p>If field 11d is marked "YES", enter the insurance plan or program name.</p>

CMS Field #	Field Label	Field is?	Instructions
10a-c	Is Patient's Condition Related to?	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	Reserved for Local Use		
11	Insured's Policy, Group or FECA Number	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	Insured's Date of Birth, Sex	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	Insured's or Authorized Person's Signature	Not Required	

CMS Field #	Field Label	Field is?	Instructions
14	Date of Current Illness Injury or Pregnancy	Conditional	<p>Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014.</p> <p>Enter the applicable qualifier to identify which date is being reported</p> <p>431 Onset of Current Symptoms or Illness</p> <p>484 Last Menstrual Period</p>
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Not Required	
18	Hospitalization Dates Related to Current Service	Conditional	<p>Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.</p>
19	Additional Claim Information	Conditional	<p>LBOD</p> <p>Use to document the Late Bill Override Date for timely filing.</p>
20	Outside Lab? \$ Charges	Conditional	<p>Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office.</p> <p>Practitioners may not request payment for services performed by an independent or hospital laboratory.</p>

CMS Field #	Field Label	Field is?	Instructions												
21	Diagnosis or Nature of Illness or Injury	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM												
22	Medicaid Resubmission Code	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.												
23	Prior Authorization	Not Required													
24	Claim Line Detail	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. Do not enter more than six lines of information on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). Do not file continuation claims (e.g., Page 1 of 2).												
24A	Dates of Service	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 <table><tr><td colspan="3">From</td><td colspan="3">To</td></tr><tr><td>01</td><td>01</td><td>14</td><td></td><td></td><td></td></tr></table> Or	From			To			01	01	14			
From			To												
01	01	14													

CMS Field #	Field Label	Field is?	Instructions
			<div> <div>From</div> <div>To</div> <div>010114010114</div> </div> <p>Span dates of service</p> <div> <div>From</div> <div>To</div> <div>010114013114</div> </div> <p>Practitioner claims must be consecutive days.</p> <p><u>Single Date of Service:</u> Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields.</p> <p><u>Span billing:</u> permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p>Supplemental Qualifier</p> <p>To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <p>ZZ Narrative description of unspecified code</p> <p>N4 National Drug Codes</p> <p>VP Vendor Product Number</p> <p>OZ Product Number</p> <p>CTR Contract Rate</p> <p>JP Universal/National Tooth Designation</p> <p>JO Dentistry Designation System for Tooth & Areas of Oral Cavity</p>
24B	Place of Service	Required	<p>Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <p>03 School</p> <p>04 Homeless Shelter</p> <p>05 IHS Free-Standing Facility</p> <p>06 Provider-Based Facility</p> <p>07 Tribal 638 Free-Standing</p> <p>08 Tribal 638 Provider-Based</p> <p>11 Office</p>

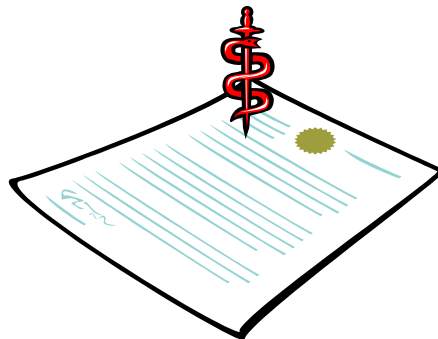
CMS Field #	Field Label	Field is?	Instructions
			12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 42 Transportation – Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 55 Residential Treatment Facility 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 72 Rural Health Clinic 81 Independent Lab 99 Other Unlisted
24C	EMG	Conditional	Enter a “Y” for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention.

CMS Field #	Field Label	Field is?	Instructions
			If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	Procedures, Services, or Supplies	Required	<p>Enter the HCPCS procedure code that specifically describes the service for which payment is requested.</p> <p>All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually.</p> <p>HCPCS Level II Codes</p> <p>The current Medicare coding publication (for Medicare crossover claims only).</p> <p>Only approved codes from the current CPT or HCPCS publications will be accepted.</p>
24D	Modifier	Not Required	
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area)</p> <p>For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <p>AV Available- Not Used</p> <p>S2 Under Treatment</p> <p>ST New Service Requested</p> <p>NU Not Used</p> <p>Family Planning (unshaded area)</p> <p>If the service is Family Planning, enter “Y” for YES or “N” for NO in the bottom, unshaded area of the field.</p>
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	<p>In the unshaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p> <p>NOTE: When billing a paper claim form, do not use the individual's NPI.</p>
25	Federal Tax ID Number	Not Required	

CMS Field #	Field Label	Field is?	Instructions
26	Patient's Account Number	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014.</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider's name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p>

CMS Field #	Field Label	Field is?	Instructions
			"Signature on file" notation is not acceptable in place of an authorized signature.
32	32- Service Facility Location Information 32a- NPI Number 32b- Other ID #	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1 st Line Name 2 nd Line Address 3 rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
33	33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1 st Line Name 2 nd Line Address 3 rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.



Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the “Claim Notes/LBOD” field.

Valid Delay Reason Codes

- 1 Proof of Eligibility Unknown or Unavailable
- 3 Authorization Delays
- 7 Third Party Processing Delay
- 8 Delay in Eligibility Determination
- 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 11 Other



The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services [Billing Manuals](#) section of the Department’s website.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to a fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>CMS 1500</i>: Indicate “LBOD” and the date in box 19 – Additional Claim Information. ➤ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks
Adjusting Paid Claims	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

Billing Instruction Detail	Instructions
Denied Paper Claims	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p> <p>Correct the claim errors and refile within 60 days of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
Returned Paper Claims	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p>Correct the claim errors and re-file within 60 days of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
Rejected Electronic Claims	<p>An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.</p> <p>Correct claim errors and refile within 60 days of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p>LBOD = the date shown on the claim rejection report.</p>
Denied/Rejected Due to Member Eligibility	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p>File the claim within 60 days of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
Retroactive Member Eligibility	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H of the Appendices in the Provider Services Billing Manuals section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
Electronic Medicare Crossover Claims	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
Medicare Denied Services	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
Commercial Insurance Processing	<p>The claim has been paid or denied by commercial insurance.</p> <p>File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.</p>

Billing Instruction Detail	Instructions
	<p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p>LBOD = the date commercial insurance paid or denied.</p>
Correspondence LBOD Authorization	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
Member Changes Providers during Obstetrical Care	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p>File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.</p> <p>LBOD = the last date of OB care by the billing provider.</p>



CMS 1500 SBIRT Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ICM/DCO#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A		3. PATIENT'S BIRTH DATE MM DD YY 10 16 45 SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
A. v829 B. v8540 C. D. E. F. G. H. I. J. K. L.		22. RE-SUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD QUAL. J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
1 01 01 15 01 01 15 23 H0049 A 29 68 1 NPI 123456789		2 01 01 15 01 01 15 23 H0050 A 64 75 1 NPI 123456789	
3		4	
5		6	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
SIGNED Signature DATE 1/1/15		28. TOTAL CHARGE \$ 94 43 29. AMOUNT PAID \$ 30. Revid for NUCC Use	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()	
ABC SBIRT Clinic 100 Any Street Any City		a. 1234567890 b. 04567890	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Resources:

SBIRT Training online at www.CMEcorner.com/SBIRT

SBIRT Training online at <http://www.sbirtraining.com/>

Ensuring Solutions to Alcohol Problems: <http://www.ensuringsolutions.org/>

SBIRT Colorado: <http://www.improvinghealthcolorado.org/>

CO Division of Behavioral Health treatment directory:
<http://www.colorado.gov/TreatmentDirectory/interview1.jsf>

Alcohol Screening/Guidelines: <http://www.alcoholscreening.org/Learn-More.aspx>

Health TeamWorks website with SBIRT Guidelines, CRAFFT, AUDIT, and DAST:
<http://www.healthteamworks.org/guidelines/sbirt.asp>

SBIRT Revisions Log

Creation Date	Additions/Changes	Pages	Made by
10/01/2010	Manual Created	All	ad, vr
06/09/2011	Manual Revised	All	ad
09/09/2011	Edited & Verified links Updated TOC Checked claim example	Throughout 1 & 2 32	jg
09/19/2011	Accepted updates Updated TOC Re-did claim example	Throughout 1 & 2 32	jg
12/06/2011	Replaced 997 with 999 Replaced wpc-edi.com/hipaa with wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3)	5 3 3	ss
06/28/2013	Manual Revised	8, 10 & 11, 15, 31	AS
08/05/2013	Updated: Program Overview Billing Information FQHC-CPT Requirements Diagnosis Codes Revised electronic billing and referred to CO-1500	3 3 10 12 4	cc
08/06/2013	Accepted changes Re-formatted Re-did claim example Updated TOC	Throughout Throughout 28 i-ii	Jg
05/22/2014	Removed references to the Primary Care Physician Program	Throughout	Mm
8/22/14	Replaced all CO 1500 references with CMS 1500	Throughout	ZS
8/22/14	Updated Professional Claim Billing Instructions section with CMS 1500 information.		ZS
8/22/14	Replaced all client references to member	Throughout	ZS
8/25/2014	Revised all weblinks to reflect the Department's new website	Throughout	MM

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.